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AUTHOR Hilton, Alan
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ABSTRACT

The paper describes interventions which can be used by parents of infants or toddlers with feeding problems. General considerations center on the critical nature of food intake, the importance of controlling events associated with feeding, and the reinforcing nature of certain adults. The paper suggests the need for selecting interventions which do not allow the child to escape the demand of eating and do not make the feeding process aversive. Three general approaches are advocated: (1) using continued demand, (2) making the eating process fun, and (3) using rewarding substances to shape appropriate eating. Frequently the approaches can be combined in an effort to teach healthy eating habits, thereby preventing more radical medical interventions. (CL)

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Approaches for Dealing With the Anorexic Infant and Toddler

Alan Hilton, Ed.D.
Assistant Professor
Eastern Montana College
1500 North 30th
Billings, Montana 59101-0298

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A number of medical conditions, including renal failure, mental retardation, cancer treatments and drugs for hyperactivity result in eating disturbances. Such failures to develop normal eating patterns are referred to by a variety of labels. Anorexia (long-term loss of appetite) and failure to thrive are probably the most commonly used terms. The problems presented by many children with medical conditions or handicapping syndromes are multipled when those same children are anorexic. Feeding problems often complicate the required medications, indicated treatments, and nutritional requirements. The very young child with such problems problems an even greater challenge because of his/her lack of language and immature reasoning ability.

All too often neither parents nor pediatricians are prepared to properly intervene with the anorexic child. Ultimately, however, the burden of feeding falls upon the parent if the child is to remain in the home. This is true whether the child is breast, bottle, spoon, or tube fed. Too often parents become frustrated, resort to use of excessive punishment techniques and/or press for hospitalization or institutionalization of the young child when such directions may not be necessary.

Although anorexia usually originates from medical conditions, if these feeding problems cannot be readily corrected, behavioral

interventions are warranted. The rationale which supports this approach is two-fold. First, the aversion behaviors that young children exhibit are learned. These learned avoidance techniques are built and strengthened because they allow the child to successfully escape environmental demands. Second, proper behavioral interventions are far less restrictive and intrusive than medical interventions which often involve removal of the child from the home.

The behavioral manifestations exhibited by infants and toddlers are quite varied and grow in sophistication as the child matures. Head-turning, teeth-clenching, physical agression, crying, vomiting, and self-mutilation are examples of behaviors commonly seen in children who wish not to eat. These behaviors are learned methods of escaping demand. The demand is the external pressure to eat placed upon the child by family members. Interventions to increase the child's eating need to be based upon the orientation of escape behavior.

Escape behavior was defined as early as 1968 by Reynolds. However, applications to specific interventions for such behaviors have not been discussed until recently (Note 1 and 2). Although only a number of studies have validated individuals' interventions to escape (Carr, 1977) quite an extensive body of research exists to support the use of behavioral approaches to remediate eating problems (see Siegel, 1982, for a summary). However, little discussion has been offered applying behavioral interventions to the anorexic child. This paper will discuss appropriate interventions which can be used by the parents of the infant or toddler who has feeding problems.

General Considerations Concerning Food and Feeding

Before attempting to work with anorexic infants and toddlers, it is necessary for parent and professional alike to change his/her thinking concerning food and the eating processes. First, this reconsideration must focus on the fact that food intake is critical to the child. This fact supercedes all other concerns, including neatness, proper manners, and independent feeding. Second, food is not reinforcing to the child. Hunger, which builds the desire to eat in other children, is not present. Food is neutral and has appeal which parallels any other object found in the child's environment. Third, efforts must be met to keep food and eating from becoming negative and aversive from the child's perspective.

There are several other factors which should be remembered by those working with the anorexic child. It is important to control events associated with feeding. For example, consumption of non-nutritious calories before and during a meal will interfere with the child's ability to consume required nutrients. The novelty aspect of food should be consistently evaluated. Foods may be reinforcing substances to a child if they are presented in varied forms. Colors, consistency, temperature, and texture can all be modified. Further, it may be necessary to vary types of foods on a daily basis. Parents should remain aware that children with eating disturbances satiate on foods quite rapidly.

Adults may also have great reinforcing value to children. A favorite adult may have greater success in getting a child to eat

than other adults. On the other hand, varying those who feed the child may provide the child with novelty while providing an individual parent with a respite from the child. Both the needs of the child and parents should be taken into consideration when making such decisions.

Effective Interventions for the Anorexic Child

When selecting appropriate interventions to feeding problems, it is important to remember the child is attempting to escape the demand of eating. Therefore it is critical to select interventions which do not allow the escape and do not turn the feeding process into an aversive experience for the child.

With those two factors in mind, many of the approaches that have proven effective in controlling mealtime behavior in other children do not work with the anorexic child. Such practices as removal of food, sending the child away, and scolding allow the child to escape the demand and/or develop an adversive relationship between the child and the adult. There appears then to be three general approaches which can be effective with the child who refuses to eat. These approaches include continuing demand, the use of fun and distraction, and shaping the eating process.

The use of continued demand is by far the least complex of those interventions. It is based upon the principle that a pre-determined amount of food or formula must be consumed no matter what the child does. This often involves the holding of the spoon or bottle in front of the child's face and waiting for the child to comply and eat.

It is important for the adult not to become emotional or angry, but to continue the demand to eat. It should be remembered that when volume is pre-established it should not be increased when the child has finished the given command. Intentional vomiting and other non-compliant activities exhibited by the child are not allowed to alleviate the requirement to eat. This approach incorporates positive verbal feedback to the child on progress he makes toward the goal of finishing his food with continued demand.

The second approach revolves around making the eating process fun for the child. This may be accomplished in two slightly different manners. The first is the provision of entertainment by the person feeding the child or by other family members. This may consist of a variety of activities including singing, eating the same or similar foods, moving around, and playing games with the child. The second variation is to provide items which are entertaining to the child. The alternatives are unlimited. However, novel and unique items to the child, such as kitchen utensils, are often quite effective. On the other hand, a favorite toy may prove to be the best for some children. Both of these approaches in practice accomplish two ends. The child does not view the feeding process as negative and may even favorably anticipate feeding time. Further, the child is distracted from food and does not attempt to escape by exhibiting unacceptable behaviors.

The final approach involves the use of rewarding substances to shape appropriate eating. The procedure uses high preference foods or liquids as reinforcement for eating. Water, for example, is often

desired by children and infants. Bites or sips on a bottle containing formula are then followed by water. Gradually, larger and larger numbers of bites or sips of food or formula are demanded for the same amount of water. Although this shaping process is slow, it is effective with some children.

Finally, it should be noted that these three interventions are not mutually exclusive. In other words, they may be paired or even used simultaneously with the same child. Parents and/or professionals should continually evaluate the approach being used with the child and should modify it when such interventions cease to be effective.

Discussion

The anorexic infant and toddler offer an immense set of problems to the parent and professional. These problems can often be overcome through appropriate and consistent interventions. The parent must rethink the eating processes, arrange the environment, and ensure that eating does not become aversive to the child. The most appropriate interventions seem to be continued demand, the use of fun, and shaping the eating process. Other more commonly accepted behavior modification approaches may compound the child's resistance to eating rather than decreasing such behavior. Use of behavioral techniques to encourage and reinforce healthy eating habits can prevent the use of more radical medical interventions which might otherwise be required to preserve the health of the anorexic child.

Reference Notes

1. Carr, E. Analysis and remediation of severe behavior problems. Paper presented at the International Symposium and Conference on Autism, Boston, July 1981.
2. Hilton, A. Dealing effectively with non-compliant students. Paper presented at the National Conference of the Association for the Severely Handicapped, Denver, 1982.

References

Carr, E. The modification of self-injurious behavior: A review of some hypothesis. Psychological Bulletin, 1977, 84, 4, 800-816

Reynolds, G.S. A primer of operant conditioning. Glenview, Ill.: Scott-Foresman, 1968.

Siegel, L.J. Classical and operant procedures in the treatment of a case of food aversion in a young child. Journal of Clinical Child Psychology. 1982, 11, 2, 167-172.